



COVERED
CALIFORNIA

Introduction to the Affordable Care Act
Participant Guide

Version 1.0

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1 INTRODUCTION TO THE AFFORDABLE CARE ACT (ACA)

This course describes the key elements of the federal health reform law passed in 2010. Subsequent courses describe in detail the steps California has taken to implement the law and to provide affordable, easily accessible health insurance for all Californians.

1.1 LEARNING OBJECTIVES

By the end of this course you will be able to:

- ✓ Understand the fundamentals of the ACA
- ✓ Understand the new health insurance options available through the ACA
- ✓ Describe the timeframe for implementing the new health insurance options in the ACA (i.e., which were implemented prior to 2014 versus those scheduled for implementation in 2014 and after 2014)
- ✓ Understand the new requirements for individuals to have health insurance
- ✓ Understand the ACA's insurance reforms
- ✓ Understand "Essential Health Benefits"
- ✓ Describe the expansion of Medicaid (Medi-Cal)
- ✓ Describe the new health insurance "Exchanges" or "Marketplaces"
- ✓ Understand the financial assistance offered to individuals and families through the new Marketplaces
- ✓ Understand the tax credits offered to small businesses

2 LESSON 1: AFFORDABLE CARE ACT OVERVIEW

In this lesson you will gain an understanding of the fundamentals of the Patient Protection and Affordable Care Act (ACA). The law passed in 2010 made significant changes to the way health insurance will be provided. Covered California is the name for how the ACA will be implemented in California. This lesson also describes the health insurance options available through the ACA and the time frame in which these changes to health insurance options will be implemented.

2.1 LEARNING OBJECTIVES

By the end of this lesson you should be able to:

- ✓ Understand the fundamentals of the ACA
- ✓ Understand the new health insurance options available through the ACA
- ✓ Describe the timeframe for implementing the new health insurance options in the ACA (i.e., which were implemented prior to 2014 versus those scheduled for implementation in 2014 and after 2014)

2.1.1 Overview of the Law

The Patient Protection and Affordable Care Act, also known as the Affordable Care Act (ACA), was signed into law in March 2010. It makes significant changes to the way health insurance will be provided and paid for in the United States with the goal of reaching near-universal coverage. Some of these major changes include:

- Insurance market reforms, such as a ban on denying coverage to people because they have a pre-existing condition.
- A new requirement that nearly everyone have coverage.
- The creation of “Marketplaces” that will give people a new way to shop for and enroll in the health plan that best meets their needs.
- Increases in the affordability of coverage through an expansion of Medicaid (Medi-Cal in California) and creation of new premium assistance and cost sharing reduction programs for those who buy Marketplace coverage.
- New initiatives aimed at making it easier and more affordable for small businesses to offer coverage.
- Improvements to Medicare such as the elimination of cost-sharing for preventive services, a new annual wellness visit, better coverage of prescription drugs, and a bolstering of the financial stability of the program.

Although not covered in detail in this training manual, the ACA also included sweeping changes to the health care delivery system in the United States, major new public health initiatives, and a range of provisions aimed at financing the ACA.

A number of the ACA improvements went into effect in the months immediately after passage, but many of the most important coverage changes will take full effect in 2014.

2.1.2 The Supreme Court's decision on the ACA

In the aftermath of its passage, the ACA was subject to a number of court challenges, primarily on the theory that its requirement that most Americans have health insurance (i.e., the “individual mandate”) was unconstitutional. On June 28, 2012, the Supreme Court confirmed the constitutionality of the individual mandate and with it, related insurance reforms central to achieving the ACA’s goal of near universal coverage. However, the Court also held that states may opt out of the second key plank in the ACA’s universal coverage structure, the Medicaid expansion for adults. As a result, states now have the option to expand Medicaid or not. California has opted to expand Medicaid.

2.1.3 ACA changes implemented prior to 2014

Most of the changes described below went into effect on September 23, 2010, six months after passage of the ACA.

Young Adult Coverage

Young adults up to the age of 26 with parents who have dependent coverage can be covered under their parents’ plan as long as they do not have access to their own employer-based coverage. Starting in 2014, they can be covered by their parents’ plan even if they do have access to employer-based coverage.

Preventive Care

All new health plans must cover specific preventive services. These services include mammograms and colonoscopies, recommended immunizations, and additional preventive care and screenings for women. Health insurance companies cannot charge copayments, coinsurance or deductibles for such services when the insured is using a doctor or hospital within the health plan’s network according to the terms of the plan.

No Lifetime or Annual Limits

Health plans no longer can impose a *lifetime* dollar limit on the essential health benefits a consumer receives. Beginning in 2014, the law also prohibits plans from imposing *annual* dollar limits on essential health benefits.

Scrutiny of Rate Increases

Federal funding is provided to states to support them in tracking, scrutinizing and reviewing proposed health insurance rate increases. Effective September 1, 2011, most individual and small group plans must participate in the rate review process.

Ensuring Premium Dollars are used for Health Coverage (“Medical Loss Ratio”)

Beginning August 2012, health plans must provide rebates to consumers if they spend too much of their premium dollars on administrative expenses, such as marketing and profit, rather than on medical care and improving health care quality. Specifically, individual and small group insurers must pay rebates if their “medical loss ratio” (the percentage of premiums spent on reimbursement for clinical services and activities that improve health care quality) is not at least 80 percent. Large group insurers must pay rebates if their medical loss ratio falls below 85 percent.

Ban on Pre-Existing Condition Exclusion for Children

Health plans are banned from imposing pre-existing condition exclusion on children under age 19. In 2014, the ban on excluding coverage of pre-existing conditions is extended to adults as part of a broader set of 2014 insurance reforms.

Other Improvements to Health Insurance

Health plans must comply with new requirements to sharply limit the circumstances under which they can cancel coverage (known as “rescissions”); provide people with better appeal opportunities; allow people to choose their primary care doctor; and provide better access to emergency rooms.

Creation of Pre-Existing Condition Insurance Plan (PCIP)

The Pre-Existing Condition Insurance Plan (PCIP) is a transitional program designed to provide coverage options to people with pre-existing conditions through January 1, 2014 when the ACA’s broader insurance reforms go into effect. Under the ACA, states were given the choice to run the PCIP program on behalf of their residents or to leave this responsibility to the federal government. Now, however, the program is running short of funds and no new enrollees are being accepted. Those already enrolled in PCIP can remain enrolled until 2014. (For California-specific information on PCIP, consumers can contact California PCIP at 1.877.428.5060).

Consumer Assistance Programs

New federal grants helped states improve their consumer assistance program. These programs provide consumers with assistance in understanding their health coverage options, enrolling in health coverage, and filing complaints and appeals.

Small Business Tax Credits

Small businesses purchasing health insurance may qualify for tax credits to help offset the cost of enrolling employees in health insurance. In 2014, the credits increase and are linked to buying coverage through the new Marketplaces.

Medicare Improvements

As of January 1, 2011, most preventive services are now free for Medicare beneficiaries, including cancer screenings, screenings for diabetes and high cholesterol, and vaccinations. To help ensure Medicare beneficiaries can take advantage of these improvements, the ACA added a new free “annual wellness visit.” In addition, the law tackles the Medicare Part D (drug coverage) “doughnut hole” or “coverage gap” (the gap historically has left Medicare beneficiaries entirely responsible for their prescription drug costs once their expenses reach a certain level, but are not yet catastrophic.) Starting in 2011, Medicare beneficiaries began receiving a 50 percent discount on brand name drugs in the coverage gap and a 7 percent discount on generics. Over time, these discounts increase until the coverage gap is entirely eliminated by 2020. Other changes in the ACA improve care coordination for Medicare beneficiaries, strengthen the low-income subsidy program for Medicare Part D, and improve the financial sustainability of the program. Note, however, that none of these changes disrupt the coverage of Medicare beneficiaries, they continue to have the same coverage options as before and are not in any way expected to enroll in the new Marketplace plans discussed below.

2.1.4 What are “grandfathered” health plans?

To avoid too much disruption in people’s existing health insurance coverage, “grandfathered” health plans are exempt from some of the ACA insurance reforms. They are plans that were in effect on September 23, 2010 that have not undergone major changes. If a plan changes significantly, it loses its grandfathered status. For example, a

plan can lose its status if it significantly increases cost-sharing or drops coverage for a particular condition.

Application of Early ACA Reforms to Grandfathered Plans	
Apply to Grandfathered Plans	Do not apply to Grandfathered Plans
Ban on lifetime dollar limits	Restrictions on annual dollar limits (in individual coverage)
Restriction on annual dollar limits (in group coverage)	Preventive health benefits with no cost-sharing.
Ban on coverage rescissions (e.g. cancellation of coverage when someone becomes ill)	Stronger appeals procedures
Coverage of young adults up to age 26	Allowing patients to choose their primary care doctor
Must spend 80 percent of premiums on health care costs (not administrative expenses)	No prior approval or higher out-of-network costs for ER use
Prohibition on pre-existing condition exclusions for children (in group coverage)	Subject to review for excessive premium increases
Requirements to provide simple summary of benefits and coverage	Prohibition on pre-existing condition exclusions for children (in individual coverage)

2.1.5 ACA changes implemented in 2014

Insurance Market Reforms

Health insurance plans in the individual and group markets (except grandfathered plans) will have to cover consumers even if they have a pre-existing health condition; even if the condition previously was a basis for denial of coverage (“guaranteed issue”). They also must renew coverage without regard to health status, use of medical services, or other factors (“guaranteed renewal”). Health insurance cannot be dropped if an insured person gets sick. Nor can coverage be denied if a consumer makes an honest mistake while completing the required information during the application process.

Accompanying these reforms are major changes in how insurers set premium levels for health plans. Insurers in the individual and small group markets may not vary the premium rate charged for a particular product based on the health status or past claims experience of a particular enrollee. Insurers are allowed to vary premiums only to reflect the geographic area in which a consumer lives, the number of people in a family covered, the age of family members (older adults can be charged up to 3 times as much as younger adults), and smoking status (smokers can be charged up to 1.5 times as much as non-smokers). States can further limit rate variation, and California has opted to do so by not allowing smokers to be charged more for their coverage.

Health Insurance Requirement

Starting in January 2014, most people will be required to have public or private health insurance or pay a financial penalty. Parents with children who are tax dependents also are responsible for ensuring those children have coverage or they may face penalties. Without this requirement, it would be difficult or impossible to implement the ACA's insurance market reforms.

Affordable Coverage and Financial Support

To make coverage more affordable, the ACA expands Medicaid and creates new premium assistance and cost-sharing reduction programs to support use of Marketplace plans. It also requires that people be given the chance to apply for financial assistance using a single, streamlined application. Sometimes referred to as the “No Wrong Door Approach,” the new application process is designed to get people into the right program regardless of where they initially submit an application.

Health Insurance Marketplaces

The ACA establishes “Marketplaces” where individuals and small businesses can shop for health insurance online, in person, by mail or by phone.

New Coverage Options for Small Businesses

The new Marketplaces include a “Small Business Health Options Program,” or SHOP, that makes it easier for small businesses to offer coverage options to their employees. The law also establishes a tax credit to support small businesses in providing health insurance to their employees.

Expansion of Medicaid (Medi-Cal in California)

Medicaid is expanded for adults under age 65 up to 138 percent of the federal poverty level (previously the ceiling was up to 133 percent). While implementing the expansion is now effectively an option as a result of the Supreme Court decision on the ACA, California will implement the expansion as originally planned. The federal government initially pays 100 percent of the cost of covering newly-eligible adults, phasing down to 90 percent in 2020. States are responsible for covering any costs not covered by the federal government. For example, this means that states will pay for 10 percent of the cost of covering newly-eligible adults in 2020 and beyond.

Essential Health Benefits

Most health plans must cover a core set of services, known as essential health benefits. This is to ensure consumers have access to necessary benefits and to create greater standardization among health plans.

Use of Standard Health Plan Options

Insurers must make most health plans available at four basic “metal” levels (Bronze, Silver, Gold, and Platinum) that vary in the share of medical expenses covered by the insurer. This concept is discussed in greater detail in the Plan Options course. The use of standardized metal tiers will help consumers to make apples-to-apples comparisons among plans and see their expected costs more easily.

Basic Coverage Plan

A “basic coverage plan,” sometimes known as a “catastrophic plan,” can be offered to people under age 30 and to others without affordable coverage options. These plans do not provide coverage of the same essential health benefits as other plans until the enrolled individual has reached the maximum out-of-pocket expenses.

Child Only Plans

Insurers that offer coverage through the new Marketplaces must make a child-only plan available to families. These plans can be used by parents and caretakers who do not need coverage for themselves, but need an option for their children.

2.1.6 ACA changes implemented after 2014

Large Employer Health Care Requirement

Employers with 50 or more full-time-equivalent employees that do not offer affordable health coverage that meets minimum standards may be subject to penalties. The penalties apply only if a company has employees who receive federally-funded premium assistance. Originally slated to be applied to large employers who failed to offer coverage in 2014, the Obama Administration delayed the large employer health care requirement by a year.

Businesses with fewer than 50 full-time-equivalent employees are not subject to a penalty for failure to offer coverage.

3 LESSON 2: MAJOR CHANGES TO HEALTHCARE WITH THE AFFORDABLE CARE ACT

As described in the previous section, there are a number of different changes to health care that were included in the ACA. This section will provide more detail on the major changes that were included in the ACA.

3.1 LEARNING OBJECTIVES

By the end of this lesson you should be able to:

- ✓ Minimum Coverage Requirement
- ✓ Development of Essential Health Benefits
- ✓ Expansion of Medicaid (Medi-Cal)
- ✓ Health insurance Exchanges or Marketplaces
- ✓ Financial assistance for individuals and families and related improvements to application procedures
- ✓ Tax credits for small businesses

3.1.1 Health insurance requirements

Health coverage is an important way to make sure people have access to medical care when they need it. It also offers people financial security by protecting them against high or unexpected medical bills. Starting in January 2014, the ACA requires that most U.S. citizens and legal residents be enrolled in health coverage that meets minimum standards. Those who do not have coverage may have to pay a penalty. This is to ensure that people can take advantage of the health and financial benefits of insurance, but also to make it possible to implement many of the insurance market reforms included in the ACA. The following are some examples of health insurance that qualifies as “minimum essential

coverage,” which is coverage that satisfies the requirement to be insured and allows people to avoid a penalty:

Examples of Minimum Essential Coverage

- | | |
|--|--|
| <ul style="list-style-type: none">• Most employer-sponsored coverage. This includes coverage offered to former employees (such as COBRA) and retiree medical coverage• Most coverage purchased in the individual market, including via a Marketplace• Medicaid (California’s Medi-Cal)• Certain types of veterans’ coverage (e.g. TRICARE)• Medicare | <ul style="list-style-type: none">• Foreign health coverage• Self-funded student health insurance plans¹• Refugee medical assistance• AmeriCorps coverage offered to AmeriCorps volunteers, which is a domestic counterpart to the Peace Corps |
|--|--|

3.1.2 People not required to have health insurance

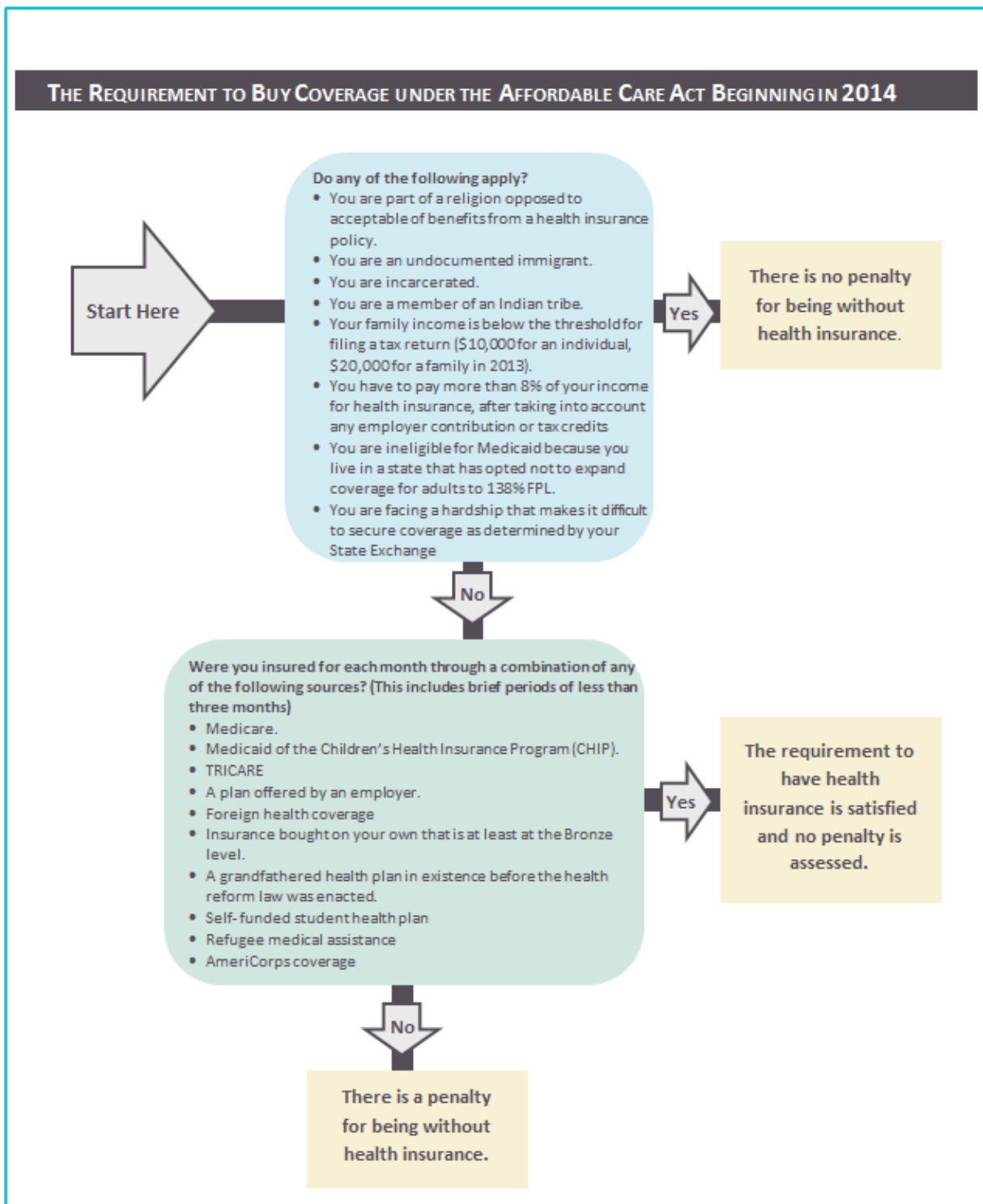
Most people are expected to have public or private health coverage in 2014. There are exceptions for people who:

- have religious reasons for not purchasing coverage,
- who cannot afford coverage, who are facing a hardship,
- or who are not required to file taxes.

In addition, people are exempt if they are:

- members of an Indian tribe,
- incarcerated,
- or not lawfully present in the United States.

The diagram below, adapted from a figure created by the Kaiser Family Foundation, explains the requirements and exemptions in more detail.



To secure an exemption from the mandate penalty under one of these categories, people need to apply for an exemption from either, 1) HHS or, 2) the IRS when they file their taxes, depending on the reason for their exemption. For example, people can receive assistance from Covered California for hardship and religious conscience exemption through the Marketplace, but can be found eligible for an affordability exemption only by the IRS. Federal regulations governing the details of what constitutes an exemption are

quite detailed, and applicants will need to meet those standards. For assistance on exemptions please contact the Covered California Service Center at 888.975.1142.

3.1.3 The penalty for not having health coverage

Consumers who do not have coverage in 2014 will be required to pay a penalty when filing their taxes at the end of the year. The penalty phases in over three years.

Pay the greater of ...		
Year	Percentage of family income above the tax filing threshold	Set dollar amount
2014	1%	\$95 per adult and \$47.50 per child (up to \$285 for a family)
2015	2%	\$325 per adult and \$162.50 per child (up to \$975 for a family)
2016 and beyond	2.5%	\$695 per adult and \$347.50 per child (up to \$2,085 for a family)
Note: The total penalty for the taxable year will not exceed the national average of the annual premiums of a bronze-level health insurance plan offered through the health insurance marketplaces.		

It is important to note that the size of a person's penalty is based on the number of months in which he or she lacked coverage. If someone has coverage for part of the year, the size of the penalty for being uninsured is adjusted to reflect only the number of months without insurance. People are allowed one brief period (less than 3 months) without coverage each year.

For example, consider a mom with two kids and an income of \$85,000 in 2016. Her tax filing threshold is \$24,000. She buys Marketplace coverage for herself and her children for January 1, 2014 – July 1, 2014, but then decides she no longer can afford the premium costs. As a result, she and her children are without insurance for six months of 2014. The Internal Revenue Service will calculate her penalty for 2014 as the greater of 2.5 percent of her income in excess of \$24,000 (\$1,525, or 2.5% of \$85,000 - \$24,000) or the per person "set dollar amount" penalty of \$1,390 (\$695 for her plus \$347.50 for each child). Since \$1,525 is greater than \$1,390, she is expected to pay \$1,525. But, first this amount is adjusted to reflect that she and her children had insurance for half of the year. Ultimately, she is left with a penalty of \$762.50 (50% of \$1,525).

3.1.4 Essential Health Benefits

In the past, there was a wide range of health insurance policies offering different benefits. Starting in 2014, most health insurance plans will share some common characteristics.

The ACA now requires that all health plans offered in the individual and small group markets must provide a core package of benefits and services, known as Essential Health Benefits.

3.1.5 Improvements to Medicaid

Background

Medicaid, known as Medi-Cal in California, is a federal-state program that offers health insurance and long-term care to low-income children, parents, pregnant women, people with disabilities, and seniors. States take primary responsibility for administering the program, but must do so within federal requirements. Both the federal government and states share in the cost of financing it.

To qualify for Medicaid, people must meet both financial and non-financial criteria, such as citizenship and immigration requirements. Originally, Medicaid primarily offered health insurance only to people who also qualified for cash assistance, such as families on welfare and people with disabilities on Supplemental Security Income. But, increasingly in recent decades, it has become a source of insurance for children and some parents in low and moderate-income working families. Even so, until passage of the ACA, it offered little or no coverage to adults without children.

3.1.6 Medicaid expansion for adults

In the ACA, Congress required states to expand Medicaid to all adults – including parents and adults without children up to 138 percent of the federal poverty level. To ease the fiscal impact on states, the federal government is covering 100 percent of the cost of newly-eligible adults in the first years of implementation. Over time, the federal government's share of the cost of covering newly-eligible adults will taper down to 90 percent. As a result of the Supreme Court decision on the ACA, states can decide that they do not want to expand Medicaid. California has opted to implement the expansion to 138 percent of the federal poverty level for adults (previously the ceiling was up to 133 percent).

The Medicaid expansion in California has the effect of significantly expanding eligibility for all adults, but especially for adults without children. Also, part of Medi-Cal is the Targeted Low-Income Children's Program (TLICP), formerly known as Healthy Families. TLICP is a low-cost insurance program for children and teens that provides health, dental and vision coverage to children who do not have other health insurance.

The expansion of Medi-Cal for adults is one way the ACA is increasing access to health insurance. The comparison looks like this:

Today	2014 and beyond
Medi-Cal coverage for adults is limited to those who meet income standards and who: <ul style="list-style-type: none">• Have a child living at home• Have a disability• Are over the age of 65• Are pregnant	Adults who are at or below 138% of FPL will qualify for Medi-Cal, including those who: <ul style="list-style-type: none">• Do not have children living at home• Have children living at home• Have a disability• Are over the age of 65• Are pregnant

The ACA makes other notable changes to Medi-Cal as well, by:

- Requiring use of a simple, streamlined application for Medi-Cal and other insurance affordability programs.
- Eliminating asset tests for children, parents, pregnant women and non-disabled adults.
- Adopting new ways of defining income when evaluating eligibility in order to allow for better coordination with other insurance affordability programs.
- Creating a new requirement to cover former foster care children up to age 26.

3.1.7 Health insurance exchanges

One of the largest components of the ACA was creating a new way to purchase coverage through Health Insurance “Exchanges” or “Marketplaces.” The Marketplaces are entities that will be set up in each state to create a competitive market for health insurance. They will offer a choice of health plans (sometimes known as “Qualified Health Plans”), establish common rules regarding the offering and pricing of insurance, help low and moderate-income people to apply for financial help to purchase and use coverage, and offer information to consumers so that they can better understand their options.

Each state can decide to operate its own Marketplace as a state-based exchange or allow the federal government to do it for them. If a state elects to have the federal government do it for them, it can opt to have the federal government provide the Marketplace altogether or still can play a significant role in its Marketplace by entering into a “partnership” model with the federal government. Under a “partnership” model, states take on some responsibilities for managing the Marketplace being operated by the federal government. For example, they can help decide which plans should be offered (i.e., take on “plan management” as a responsibility) and/or help in designing consumer assistance. The federal government, however, ultimately remains responsible for running the Marketplace in partnership model states.

California has elected to run its own Marketplace, which is known as “Covered California.” As required under federal law, Covered California will launch its initial open enrollment period on October 1, 2013. People who enroll in Qualified Health Plans through Covered California will have coverage that goes into effect as early as January 1, 2014.

3.1.8 Who is eligible to enroll in coverage through the new Marketplaces?

The ACA authorizes the Marketplaces to make health plans available to qualified individuals and employers.

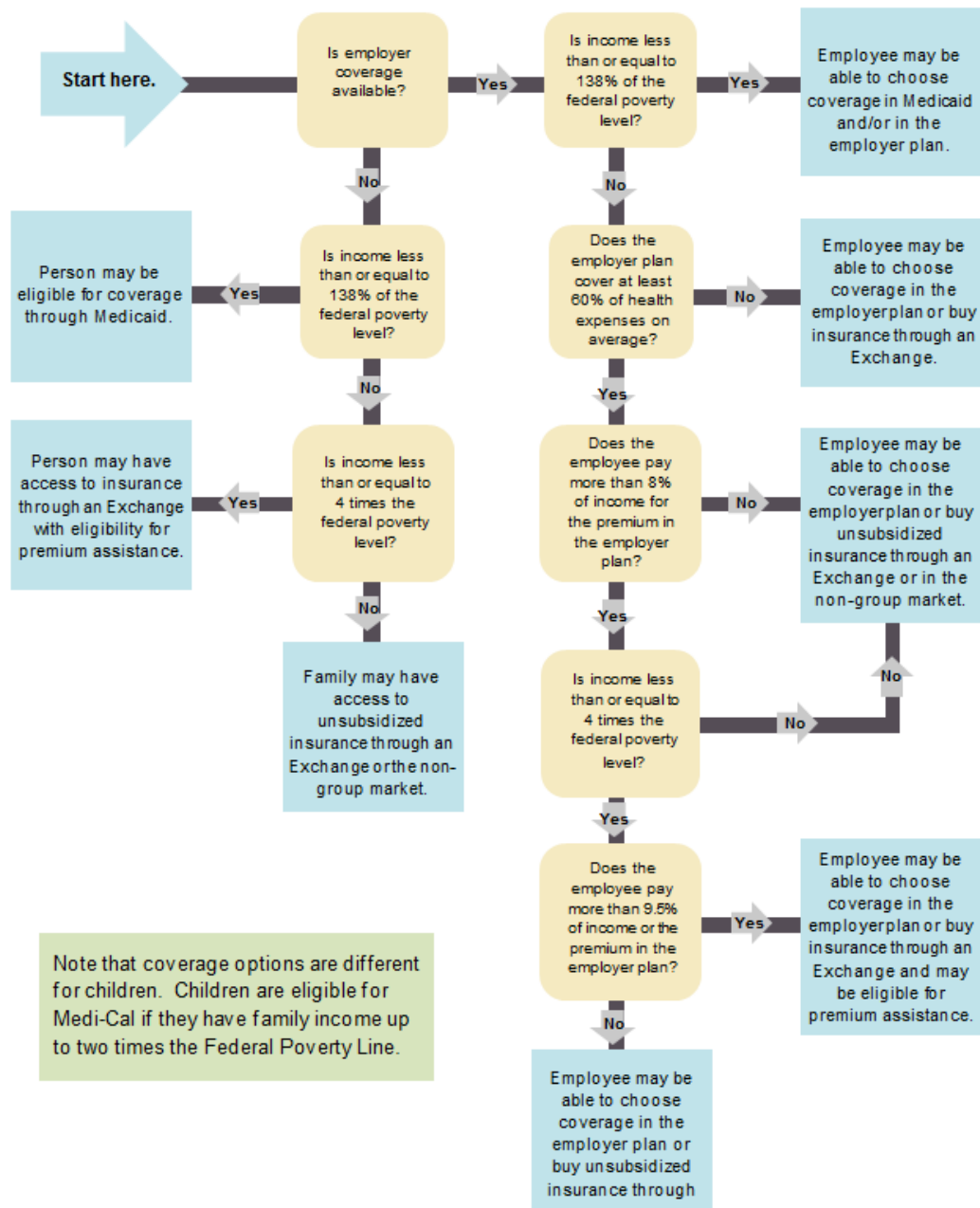
To be eligible to enroll in a Qualified Health Plan, an applicant must meet the following requirements:

- Be a citizen or national of the United States, or a non-citizen who is lawfully present in the United States;
- Not be incarcerated (other than incarceration pending the disposition of charges); and
- Be a resident (or have the intent to be a resident) of the state in which one wants to purchase insurance.

Small businesses with fewer than 50 employees also can use the new Marketplaces to offer coverage to their employees. The small business component of Marketplaces is known as the “SHOP,” which stands for the “Small Business Health Insurance Options Program.” In some instances, small businesses may qualify for federally-funded tax credits to help reduce the cost of providing coverage to their employees if they elect to participate in the SHOP.

The chart on the following page provides an overview of how consumers can access the new Marketplace. Each of these paths will be described in detail during this training.

How Adults Get Health Coverage under the Affordable Care Act Beginning in 2014



3.1.9 How will Marketplaces be structured?

A State-Based Marketplace must be a government agency or nonprofit entity that is established by a state. (While the ACA refers to “Exchanges,” the federal government has decided to refer to them as “Marketplaces.”)

- States may choose to establish Marketplaces for individuals and small business employees (Small Business Health Options Program, or SHOP, Exchanges). They are expected to be operational and to begin accepting applications on October 1, 2013, with health insurance coverage starting January 1, 2014.
- If a state does not elect to set up a Marketplace, the Department of Health and Human Services (DHHS) will establish and operate a Marketplace in that state, either directly or through an agreement with a nonprofit entity.
- Funding to establish Marketplaces is available to states until January 1, 2015. After this date, states must find alternative ways to finance the cost of operating Marketplaces.

3.1.10 What functions will Marketplaces perform?

The primary function of a Marketplace is to provide consumers a place to compare health coverage plans and purchase one that works best for them, as well as to connect them with financial assistance to make health coverage more affordable.

Under the ACA, there are many specific functions that a Marketplace is required to perform. The following is a list of some of those major functions:

- Screen and certify health plans as “qualified” to be offered in the Exchange
- Provide standardized information about health plans to consumers via a Web site, including the premiums, cost-sharing charges, benefits, providers networks and quality rating of health plans, to help inform consumer choice.
- Operate a toll-free telephone assistance hotline, an internet website, and offer in-person consumer assistance designed to help consumers understand their options, enroll in plans and secure financial assistance.
- Allow people to apply for coverage using a single, streamlined application that may be used to apply for Medi-Cal (California’s Medicaid) as well as coverage offered by the Marketplace. The application may be submitted to the Marketplace online, in person, by mail, or by telephone.
- Make available an electronic calculator to determine the actual cost of coverage.

3.1.11 What benefits will be offered through the Marketplaces?

The health insurance companies that participate in the Exchanges will be required to offer a uniform set of benefits, known as essential health benefits. Essential health benefits must include items and services within at least the following 10 categories:

Essential Health Benefits

- Ambulatory patient services, such as visits to a doctor for an illness and services provided by an outpatient clinic.
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Rehabilitative and habilitative services and devices. These include physical, occupational, and other therapies and treatments to help people regain function after an accident or illness, (“rehabilitative” services) or to help them maintain (rather than regain) their ability to function on a daily basis (“habilitative services”).
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including dental and vision care
- Prescription drugs

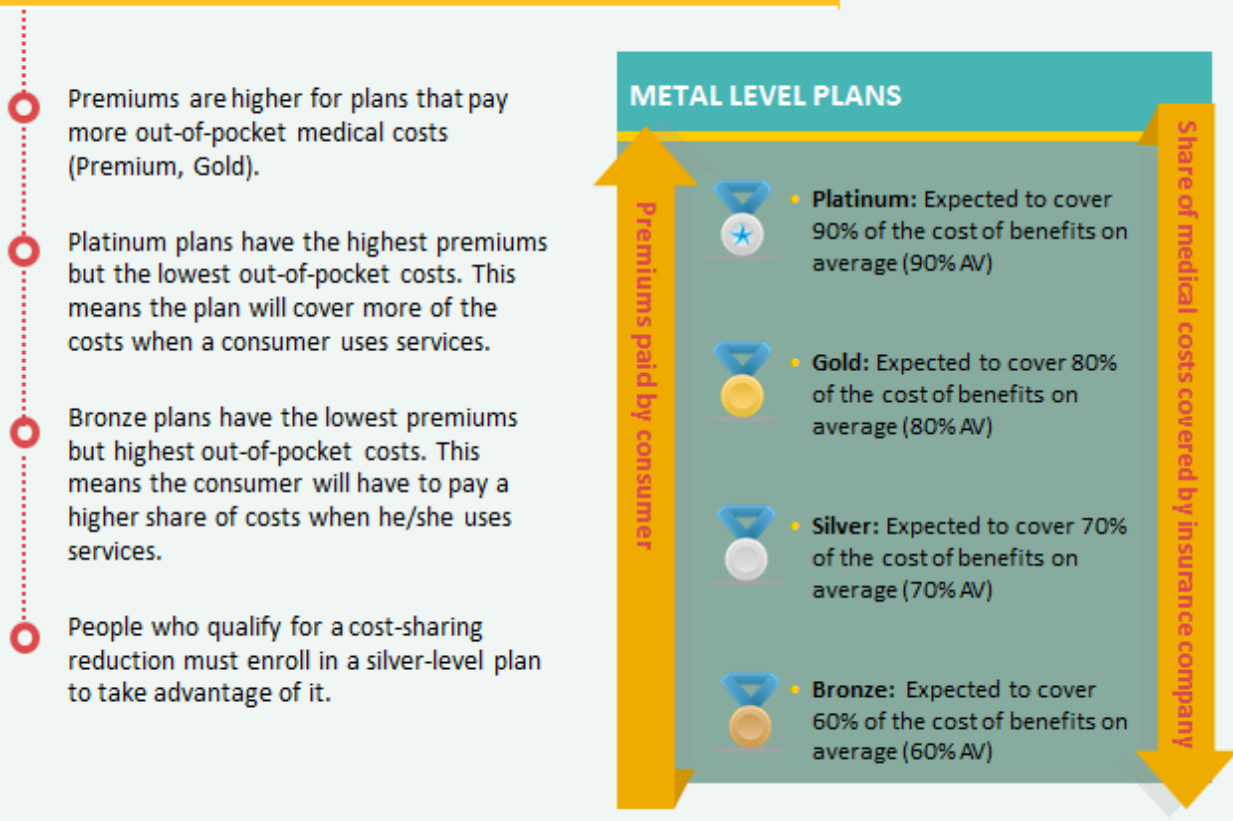
In California, the health plans offered through the Marketplace are standardized – meaning they offer the same basic benefits so that consumers can make “apples-to-apples” comparisons when selecting a plan.

3.1.12 What types of plans will be offered?

Metal Levels of Coverage

The Marketplaces will offer four major levels of coverage: Bronze, Silver, Gold, and Platinum. Each type of plan must cover essential health benefits, but they differ in the share of health care costs covered. On average, a Bronze plan will cover 60 percent of covered benefits, a Silver plan 70 percent, a Gold plan 80 percent and a Platinum plan 90 percent. Consumers pay for the remaining cost of their medical expenses with their own funds through deductibles, co-insurance and co-payments. The “higher” a metal level, the more expensive the premium (i.e., the cost of enrolling in the plan). On the other hand, plans with a higher metal level cover more of consumers’ medical expenses on average after they are enrolled in insurance.

Metal Levels and Premiums



It is important to note that the metal level of a plan indicates how much on average the plan is expected to cover of medical expenses versus the consumer. Any given individual might have to cover more or less of the cost of the health care services he or she uses, depending on the person's particular medical needs.

However, all plans must offer an annual limit on the amount of money consumers must pay out-of-pocket in the form of deductibles, co-insurance and co-payments. This limit is designed to provide consumers with protection if they face extremely high health care costs. After consumers meet their out-of-pocket maximum, their plans are obligated to cover 100% of their expenses for covered benefits. In 2014, the out-of-pocket maximum will be \$6,350 for self-only coverage and \$12,700 for family coverage. Some individuals with low incomes must be offered plans that have lower cost-sharing maximums.

Child-only plans

Insurers who offer plans on the Marketplace must offer a child-only product. The child-only product allows people to purchase coverage for their children under the age of 21 even if they do not need it for themselves.

Basic coverage plans

Marketplaces also must make available catastrophic or basic coverage plans to people under 30, as well as to individuals who are exempt from the mandate to purchase coverage because they have an affordability or hardship exemption. A basic coverage plan covers essential health benefits, but only after out-of-pocket cost sharing reaches a high deductible that will match the level of the ACA's required out-of-pocket maximum. In 2014, that is \$6,350 for self-only coverage and \$12,700 for family coverage.

Pediatric dental plans

Under the essential health benefit requirements, plans must provide pediatric services, including oral and vision care. Under the ACA, Marketplace plans are not obligated to include pediatric dental benefits if standalone dental plans are also being sold on the Marketplace.

The rules governing standalone dental plans are different from those of other Marketplace plans. Standalone dental plans are not subject to the “metal” system, but rather come in two forms: a “low level” that is expected to cover 70 percent of covered expenses and a “high level” that is expected to cover 85 percent of covered expenses.

3.1.13 Financial assistance for individuals and families

To help low-to-moderate-income individuals and families purchase coverage the Exchanges are required to offer people the opportunity to apply for financial assistance using a single streamlined application. As discussed in more detail in other courses (see the Eligibility for Individuals and Families course), the financial assistance can take the form of Medi-Cal, premium assistance (or tax credits) to support the purchase of coverage, and cost-sharing subsidies to reduce consumers’ out-of-pocket costs when they use health plans.

3.1.14 Medi-Cal

Medi-Cal is California’s Medicaid program for low-income people. The program has covered many low-income children, pregnant women, parents, people with disabilities and seniors. Beginning January 1, 2014, it will be expanded to cover more low-income childless adults.

3.1.15 Premium assistance (or tax credits)

Premium assistance offers eligible individuals a tax credit to help pay for the cost of purchasing a health plan through a Marketplace. People can elect to take the credit on an “advance” basis if they need immediate help with their premium costs, or they can receive the credit when they file their income taxes. To qualify, people generally must have income between 100% and 400% of the federal poverty level and meet a range of non-financial criteria, including a requirement that they lack access to other affordable insurance options.

The amount of premium assistance is based on a sliding scale, with those who make less money getting a larger amount of financial support to lower the cost of their insurance premiums.

To obtain premium assistance, consumers must enroll in a health plan through Covered California.

Following are some examples of premium assistance.²

	Healthcare Premium	Premium Assistance	Premium After Assistance
Joan is a 40-year-old single mother with three kids. She earns about \$35,000 per year.	Joan's health insurance premium could be as much as \$12,336 per year or \$1,028 per month.	Under the ACA, Joan qualifies for \$10,908 in premium assistance or \$909 a month.	Joan pays \$1,428 per year after applying premium assistance for a Silver plan. Her monthly payment is about \$119.
Henry and June are married with two children. They earn about \$50,000 per year.	Like Joan, Henry and June's total health insurance premium is about \$12,336 a year or \$1,028 a month.	With their income, Henry and June qualify for premium assistance in the amount of \$8,892 or \$751 a month.	The premium assistance brings the annual premium for a Silver plan selected by Joan and Henry down to \$3,444 – or \$287 a month.
Tory is 22 and unmarried. She earns about \$18,000 each year.	Tory's annual health insurance premium is about \$3,408 a year or \$284 a month.	Tory qualifies for \$2,607 in premium assistance a year or \$217 a month.	Her annual premium is now \$816 or about \$68 each month.

3.1.16 Cost-sharing subsidies (“Enhanced Silver” Plans)

Cost-sharing subsidies reduce the amount that people are expected to pay when they use the services of a Marketplace health plan, such as deductibles, co-insurance and/or co-payment charges. Cost sharing subsidies, also referred to as “cost-sharing reductions,” (CSR) are available to individuals enrolled in Marketplace Silver plans. Consumers can enroll in and use both premium assistance and cost-sharing reductions called “Enhanced Silver” plans.

Cost-sharing subsidies work by increasing the share of medical expenses that plans cover and reducing the share paid out-of-pocket by consumers. Plans can pick up a greater share of medical expenses by reducing deductibles, co-payments or co-insurance. They also can provide more cost sharing protection by reducing out-of-pocket maximums.

The amount of help provided by a cost sharing subsidy depends on a person's income - more substantial help is available to people at lower income levels. There are three different levels of savings available shown in the table on the following page:

CSR Tier	Income Range	Actuarial Value of the Silver Plan
1	Special populations < 100% FPL; 100% FPL - 150 %FPL	94%
2	150% FPL - 200% FPL	87%
3	200% FPL - 250% FPL	73%

Silver plan variations offered in these levels

3.1.17 “No Wrong Door” enrollment opportunities

Since there are a range of insurance affordability programs for which people might qualify, the ACA includes a number of provisions aimed at making it easier for people to apply for and enroll in the right program. Most importantly, Medicaid agencies and the new Marketplaces must offer people the opportunity to complete a single, streamlined application that allows people to be evaluated for Medicaid (Medi-Cal), the Targeted Low-Income Children’s Program (formerly Healthy Families in California and now TLICP), premium assistance and cost-sharing reduction. People do not need to know in advance which program they qualify for they can submit the single application to a Medicaid agency or a Marketplace and still be evaluated for all insurance affordability programs.

People must be given the chance to submit the single, streamlined application online, by phone, in-person or through the mail.

3.1.18 Small Business tax credits

The ACA includes small business tax credits to help make employee health insurance more affordable for the employer. Beginning in 2014, eligible small businesses can secure the tax credit only if they purchase coverage for their employees through the Small Business Health Options Program (SHOP).

Employers with 10 or fewer full-time equivalent employees with wages averaging \$25,000 or less (in 2014 and beyond, this figure is adjusted) are eligible for the maximum tax credit.

Nonprofit or tax-exempt employers must meet the same criteria as other small businesses and their premium assistance will be somewhat lower.

3.1.19 Eligibility

Small businesses may be eligible for tax credits if they:³

- Have 25 or fewer full-time equivalent employees for the tax year
- Pay employees an average of less than \$50,000 per year (in later years, this figure will be adjusted).
- Contribute at least 50 percent toward employees' premium costs. This contribution requirement also applies to add-on coverage such as vision, dental, and other limited-scope coverage

3.1.20 Tax credits amounts and duration

The amount of tax credits depends on a number of factors including the number of full-time equivalent employees and the amount the employer spends on insurance premiums.

Tax credits will become more generous starting in 2014. Tax credits are available for a total of two consecutive years.

The table below illustrates the two phases of tax credits to help employers with 25 or fewer full-time equivalent employees cover premium costs.

	Tax Year(s)	Maximum Tax Credits for Businesses as a Percentage of Insurance Premium Expenses	Maximum Tax Credits for Tax-Exempt Organizations as a Percentage of Insurance Premium Expenses
Phase One	2010 – 2013	35%	25%
Phase Two	2014	50%	35%

3.1.21 Phase one covers tax years 2010 through 2013

During this time, there is sliding-scale tax credit of up to 35 percent of the employer's eligible premium expenses.

- Employers with 10 or fewer full-time equivalent employees and paying annual average wages of \$25,000 or less qualify for the maximum amount of tax credits.
- For tax-exempt employers, the same employee and wage requirements apply, but the maximum amount of tax credit is 25 percent of eligible premium expenses during the first phase.

3.1.22 Phase two begins in tax year 2014

The maximum amount of tax credits increases to 50 percent of premium expenses and coverage, as long as coverage is purchased from Covered California. For tax-exempt employers, the maximum amount of tax credits increases to 35 percent in 2014.

Later in 2013, Covered California will have more resources available to help small business owners understand their eligibility for tax credits. It is a good idea for small businesses to check with their tax/financial advisers about their eligibility for tax credits.

Small Business Tax Credit Example

	Beauty Shop with 10 Employees	Restaurant with 40 Part-Time Employees
Business	Main Street Hair	Downtown Café
Employees	10 full-time equivalent employees	40 half-time employees (equivalent to 20 full-time workers)
Wages	\$250,000 total or an average of \$25,000 per employee	\$500,000 total or an average \$25,000 per full-time equivalent worker
Employee Health Insurance Cost	\$70,000	\$240,000
2013 Tax Credit	\$24,500 (35%)	\$28,000 (12%)
2014 Tax Credit	\$35,000 (50%)	\$40,800 (17%)

4 ACTIVITIES

Check your knowledge. Answer True or False.

	True	False
1. Starting in January 2014, no one will be denied health insurance due to pre-existing conditions.		
2. There will be penalties for people who choose not to have insurance coverage.		

Match the following questions with the correct response.

1. I don't have health insurance right now. What do I qualify for?	<p>A. Yes, you can shop for Covered California health plans. However, if your employer sponsored coverage employee's share of the annual premium for self-only coverage is no greater than 9.5% of the annual household income. A plan is considered affordable if the person is required to contribute 8% or less of their income towards the plan.</p> <p>B. This can be answered several ways: Certified Enrollment Assistance Personnel (i.e. Agents, Counselors, etc.) can help you with specific eligibility questions; however if you have insurance through your employer, your employer may cover your child under your policy if they are age 26 or below. Depending on your income level and other qualifications, they may be eligible for the Targeted Low-Income Children Insurance Program option with Medi-Cal.</p> <p>C. Certified Enrollment Assistance Personnel (i.e. Agents, Counselors, etc.) can help you determine exactly what you qualify for.</p> <ul style="list-style-type: none"> Basically, what you qualify for depends on your income level You may qualify for Medi-Cal for lower incomes You may qualify for coverage with premium assistance You will have a variety of coverage levels to choose from between HMO and PPO plans and then there will be different metallic tiers of coverage
Answer:	
2. I have insurance through my employer but it's too expensive. Can I get insurance through Covered California?	
Answer:	
3. I need to purchase health insurance for my 18-year-old son. What does he qualify for?	
Answer:	

5 ACTIVITY ANSWERS

Activity A

1. True
2. True

Activity B

1. C
2. A
3. B

6 ENDNOTES

¹ Self-funded student coverage with a plan year that begins on or before December 31, 2014 is treated as minimum essential coverage under final rules issued by the Department of Health and Human Services (HHS). Colleges and universities must apply to HHS if they want to have their self-funded student health insurance plans treated as minimum essential coverage after this date.

² Examples developed by Covered California, accessed at www.coveredca.com/resources/calculating-the-cost/

³ “Small Business Tax Credit” Fact Sheet: www.CoveredCa.com